Reforming the Medicare Home Health Benefit

Introduction

Thank you, Mr. Chairman, for the opportunity to testify today. I am pleased to discuss the Medicare home health benefit and the Administration's efforts to reform the benefit. The Administration is committed to reforming the way we pay for home health services and we look forward to working with the Congress on these reforms. The Administration is also taking a number of administrative steps to reform the benefit and I am pleased to discuss these as well.

Description of the Benefit

Under the home health benefit, Medicare pays for skilled health care and other services related to the treatment of an illness or injury. To receive home health care, a beneficiary must be under the care of a physician who has determined that medical care in the home is necessary and who has prepared a plan of care. Furthermore, the beneficiary must be confined to the home and must need intermittent skilled nursing care, or physical therapy or speech language pathology services. Finally, care must be provided by a Medicare-certified home health agency (HHA). If these requirements are met, Medicare will pay for:

Skilled nursing care, either on an intermittent or part-time basis, but not full-time. Skilled nursing care includes skilled observation and assessment, administration of medications, wound care, ostomy care, venipuncture, and other services performed by licensed nurses.

Physical therapy, occupational therapy, and speech language pathology, for as long as they are medically necessary and reasonable. These services help beneficiaries restore movement and muscle strength, achieve independence in daily living, and restore speech.

Medical social services, to assess the social and emotional factors related to the illness and to search for available community resources.

Home health aide services, either on a part-time or intermittent basis, but not full-time. These services include assistance with personal care (such as feeding, bathing, using the toilet, or dressing) and routine care of prosthetic and orthotic devices. Medicare does not pay for personal care if it is the only care that the beneficiary needs. Medicare also does not pay for homemaker services such as shopping, cleaning, and laundry.

Medical supplies, like wound dressings, braces, blood drawing and intravenous supplies.

Durable medical equipment, like wheelchairs, walkers, and oxygen equipment. For DME, beneficiaries must pay the 20 percent Part B coinsurance.

Other than for DME supplies, there is no beneficiary co-insurance.

As expected, Medicare beneficiaries using home health services tend to be in poorer health than the general Medicare population (see chart). Two-thirds are women, and one-third live alone. Forty-three percent have incomes under $10,000 per year.

Growth in Expenditures and Utilization

Expenditures for home health services are one of the fastest growing components of Medicare. Expenditure growth is due to the increase in the number of visits per beneficiary (intensity), the growth in the number of beneficiaries using home health services, and the growth in the number of HHAs serving beneficiaries.

In terms of intensity growth, consider that in 1980, the average home health beneficiary used 22 visits. This number grew to 33 visits in 1990, and about 76 visits per user for 1996.

In terms of growth in the number of beneficiaries using the benefit, in 1980, 700,000 Medicare beneficiaries used the benefit. By 1990, 1.9 million, or 5.6 percent, of Medicare beneficiaries had received home health services. This has increased to about 3.7 million, or 10.1 percent of beneficiaries, in 1996.

Finally, the number of HHAs participating in Medicare has grown from 3,125 in 1982 to 5,656 in 1990, to over 9,800 in 1996.

We have also seen that there is a dramatic variation in the use and cost of services across regions of the country and even among States. For example, in 1994 the average number of visits per beneficiary was 126 in Louisiana, 76 in neighboring Arkansas and in Florida, 97 in Texas, 45 in New York, 46 in California, and 40 in Oregon. The national average visits per user in 1994 was 66. Expenditures per person served vary widely, too. The national average program payments per home health user in 1994 was $4,016. Compare this to $6,700 in Louisiana, $4,595 in Florida, $3,334 in New York, and $3,118 in Oregon.

Reasons for Expenditure and Utilization Growth

The dramatic increase in utilization and expenditures for home health is due to a number of factors, including policy changes, changing demographics, medical advances, and increases in demand by beneficiaries and physicians. With respect to policy changes, some had unintended consequences. While they were often undertaken with the belief that they would reduce total costs by shifting resource use from more expensive (hospital) to less expensive (post-acute care) settings, for the most part, these policy changes were not systematic attempts to reform Medicare. Rather, they occurred piecemeal throughout the years to achieve specific objectives. And, they may not have resulted in a reduction in total Medicare costs.

OBRA 1980 Liberalization

For the first fifteen years of the Medicare program, there were two distinct home health benefits: a post-hospital home health benefit under Part A of the program, and a general home health benefit under Part B. When Medicare was created in 1965, Part A (financed by the Hospital Insurance, or HI Trust Fund) was designed to cover only hospitalizations and short-term, recuperative, post-acute care in the home or other facilities. The coverage and eligibility rules of the post-hospital home health benefit reflected this emphasis. The Part A benefit was limited to 100 visits available to those beneficiaries who were discharged from a hospital following a minimum 3-day stay. There was no beneficiary cost-sharing for the Part A benefit. The Part B benefit did not have a post-acute care focus and as such did not have a hospital stay requirement. It covered 100 visits during a calendar year. The Part B deductible applied to the Part B home health benefit and, until 1973, beneficiaries were required to pay coinsurance for their Part B visits.

In the Omnibus Budget Reconciliation Act of 1980 (OBRA 1980), Congress eliminated the 3-day prior hospitalization requirement under Part A, eliminated the 100-visit limits for both Part A and Part B, eliminated the deductible for home health services under Part B, and permitted proprietary HHAs to receive Medicare payments.

In effect, OBRA 1980 transformed the home health benefit into an unlimited benefit -- one that serves the chronic needs of patients as well as the needs of those who require more short-term, recuperative care after a hospital visit. Because Part B home health services are only used now by that small group of beneficiaries who are not enrolled in Part A, the OBRA 1980 change had the unintended result of burdening the HI Trust Fund with financing approximately 99 percent of the home health benefit, regardless of whether visits are related to a hospital stay. As you are aware, this is a problem we seek to fix in our legislative proposals.

OBRA 1980 also allowed for Medicare certification of proprietary home health agencies. Payment to proprietary agencies -- which now represent 48 percent of all certified agencies -- are the fastest growing segment of Medicare home health expenditures. One analysis suggests that beneficiaries receiving care from proprietary HHAs receive 21 more visits, on average, than those receiving care from non-profit agencies, even after controlling for the differences in health and functional status of the beneficiary, as well as age, sex, and living situation.

Duggan v. Bowen

In the early 1980s, HCFA attempted to control excessive growth in utilization through enhanced review of claims, more detailed reporting, and other measures. However, these attempts were thwarted by a 1988 court case, Duggan v. Bowen, the settlement of which resulted in a re-interpretation of the "part-time or intermittent" eligibility criteria in a way that vastly expanded the benefit's coverage. The impact of the Duggan settlement, on top of the OBRA 1980 changes, had a dramatic impact on home health utilization, as noted by the

General Accounting Office (GAO) in its March 1996 report on Medicare Home Health Growth (GAO/HEHS-96-16).

In the aggregate, as a result of the OBRA 1980 changes and the Duggan settlement, we have witnessed a steady growth in the number of home health visits per user and the number of users. Much of the growth in home health outlays is due to patients who receive more than 100 visits per year. The Duggan settlement has been the catalyst for a 38 percent annual increase in home health expenditures from 1988 to 1992, and a 167 percent increase in visits per beneficiary from 1989 to 1995.

Impact of Hospital PPS

The implementation of the Prospective Payment System (PPS) for inpatient hospitals also resulted in increased utilization of post-acute services such as home health, skilled nursing facility services (SNFs), and rehabilitation services. Hospital PPS provides payment to hospitals on the basis of diagnosis rather than the actual costs incurred by the hospital in providing care to each patient. Hospitals responded to the incentives in PPS by, among other things, shortening the lengths of stay. Patients were discharged earlier, with less complete recovery, resulting in increased use of post-acute services. There has been a significant shift in Medicare spending from PPS hospitals to post-acute providers such as home health agencies. In 1986, acute care hospitals received more than 91 percent of Medicare Part A payments whereas post-acute care providers received less than 9 percent of Part A payments, with HHAs receiving 4 percent. In 1993, however, the percentage of Part A payments to hospitals decreased to less than 74 percent in 1993, while payments to post-acute care providers increased to more than 26 percent, including 10.5 percent to HHAs.

Changing Demographics, Medical Advances, and Increases in Patient Demand

Changing demographics, medical advances, and increases in demand by beneficiaries and physicians have all contributed to increasing expenditures. Medical advances, for example, have expanded the range of patients who can benefit from certain therapies, and have made it possible to provide interventions (such as intravenous drug therapy) in the home. Certainly, shifts in demographics have had an immense impact on the use of post-acute and long-term care services. Studies show that home health care is serving many more of the older elderly population who require longer term care. Physicians and beneficiaries are increasingly showing a preference for home health care over other modalities. In addition, HHAs are now aggressively marketing their services to physicians to stimulate demand.

Fraudulent, Abusive, and Wasteful Practices

Our review of the supporting documentation for claims from some HHAs has revealed alarming instances in which Medicare was billed for unnecessary or inappropriate. The Medicare claim "error rate" was high as 75 percent in the case of one agency in Florida; that

means that 75 percent of the claims for that agency should not have been paid. Other HHAs have had high error rates as well, and about a quarter of claims from the industry overall seem to be inappropriate.

Most of the erroneous claims are for care that simply is not necessary -- that occur solely for the purpose of earning money for the agency. Other erroneous claims are for services that are not furnished at all or for beneficiaries who were not homebound. In addition, there were significant numbers of instances in which the services were never ordered by a physician, or where physician orders were forged. Finally, when there were physician plans of care for Medicare beneficiaries, in too many instances the care that the beneficiary received was different from that necessary for their recovery. As serious as it is to provide unnecessary services, it is even more serious to fail to provide services that are necessary.

While we do not want to discourage appropriate use of the benefit, we simply cannot afford to tolerate the fraudulent and abusive practices that exist in some parts of this industry. Current law contains loopholes whereby providers can be paid excessive amounts. As I'll describe later, we have several legislative proposals in the President's budget to close these loopholes. These legislative proposals build on the successes of our anti-fraud initiatives such as Operation Restore Trust (ORT) and the Medicare Home Health Initiative.

HCFA Administrative Efforts to Stem the Growth of Inappropriate Utilization and Costs

I want to reassure the Congress that HCFA has intervened where possible to stem the growth of inappropriate utilization. I want to describe in some detail efforts we have undertaken, or are undertaking, to address this concern.

Almost four years ago, I commissioned the Medicare Home Health Initiative, an agency-wide, comprehensive assessment of the home health care benefit. The Initiative involved consultation with representatives from consumer groups, the home health industry, professional organizations, fiscal intermediaries, and State agencies. The Initiative has spawned various efforts to make a number of improvements to the benefit and, where possible, assert greater control over inappropriate utilization.

Conditions of Participation and OASIS

As you are probably aware, we will soon publish revisions to the Medicare Conditions of Participation (CoPs) for HHAs and a requirement that HHAs collect information relating to an Outcomes and Assessment Standard Information Set (OASIS). In tandem, these rules will hold HHAs accountable for better, more accurate patient assessment, care planning, coordination of service delivery, and quality assessment and performance improvement. Among other things, these rules would require agencies to:

- Systematically assess patients to improve patient outcomes and to allow the physician,

agency practitioners, and the patient to make more appropriate clinical treatment decisions. This OASIS data must be routinely collected and analyzed by each HHA. This assessment data will form the basis of our ability to monitor individual agencies' overall quality performance, focus external survey efforts on the detection of instances where patients may be receiving fewer or more visits than necessary to achieve expected outcomes, and foster improved home health care outcomes nationally.

- Implement quality assessment and performance improvement programs. The proposed rule would raise the performance expectations for agencies by requiring them to develop, implement, and maintain a data-driven continuous quality review and performance improvement program.

- Improve care planning and coordination of services to reduce redundant or conflicting treatments, eliminate confusion for the patient, and generally improve the level of care.

- Safeguard continuity of care by holding agencies responsible for the interdisciplinary coordination and provision of all services ordered under that patients's physician-prescribed plan of care. This standard addresses a current problem in which an agency may treat a patient for only specific services and then refer that patient to several other agencies for the remainder of the treatment.

- Strengthen patient rights protections and add to the current protections by requiring agencies to (1) provide patients in advance with more detailed information on the care and treatment to be provided, and (2) inform patients about expected outcomes and any barriers to treatment.

- Require that a majority of services (nursing, therapy, social work and home health aide) services furnished to home health patients be provided directly by staff employed by the HHA, rather than by contracted personnel. This reflects HCFA's belief that excessive use of contracted personnel may indicate that an agency is not exercising the appropriate level of control over quality of care, or that an agency may be exceeding its patient capacity. This standard would also better ensure coordination of care and care planning.

Revised HHA Manual

We also recently overhauled our provider manual to provide better guidance to agencies on the complex home health eligibility and coverage rules. We expect this greater clarification to reduce the amount of inappropriately furnished services that are billed to Medicare.

Physician Outreach

We have also worked to increase physician involvement in the monitoring of home care services. Physician involvement in care plan oversight is critical to ensure that the appropriate

level of care is being provided. We need to avoid situations in which physician certification is merely a rubber stamp of a plan of care that has been completed by a home health agency. HCFA is now reimbursing physicians for care plan oversight to engage physicians in the careful planning of home care services. We are also involved in a number of efforts to educate physicians about the home care benefit. For example, HCFA has developed home health public service announcements and other materials to educate physicians and their staffs regarding developing a plan or care, monitoring patient progress, and detecting fraud and abuse.

Beneficiary Outreach

We are better educating beneficiaries about the home health benefit in an effort to help them recognize instances of inappropriate care or fraud and abuse. We have published a new home health brochure and have produced a video that is shown in hospital and office settings. This year, we began sending Notice of Utilization statements (NOUs) to beneficiaries to inform them of the services being billed on their behalf so that they can detect any aberrancies.

Operation Restore Trust (ORT) Initiatives

In May 1995, President Clinton and Secretary Shalala launched ORT to improve efforts at detecting and eliminating Medicare and Medicaid fraud, waste, and abuse. ORT is targeting four areas of high spending growth, including home health care, in the five Sates that comprise more than one-third of all Medicare and Medicaid beneficiaries -- New York, Florida, Illinois, Texas, and California. ORT has provided additional funding to allow for enhanced surveys on facilities for which allegations of questionable activities have been received or that may have inappropriately billed Medicare.

These enhanced ORT surveys facilitate the sharing of information between regional home health intermediaries (RHHIs) and surveyors. Because surveyors make onsite visits to home health agencies and to beneficiaries receiving services, they can identify information that can assist an RHHI in making determinations about the appropriateness of claims. State survey agencies are asked to identify and gather information on behalf of RHHIs concerning the homebound status of beneficiaries, home health services billed but not rendered, and inappropriate billing of supplies. HCFA has learned that often where there is fraudulent billing, there are also quality deficiencies. Thus, the information from the RHHI helps the surveyors focus on providers who are more likely to be delivering substandard care or otherwise failing to meet CoPs. HCFA will be continuing to encourage the collaboration between RHHIs and State survey agencies teams and expand this survey process to other States.

We will continue our diligence in attempting to stem the tide of inappropriate home health utilization. As the GAO noted in its March 1996 report on Medicare home health growth, HCFA is working to gain greater control over the use of the home health benefit.

Legislative Proposals

The Broader Context for Payment Reform: An Integrated Payment System

Before I delve into the specific legislative proposals, I want to emphasize that our HHA payment proposal should be viewed as an interim step to an integrated payment system for post-acute services. Many argue that the post-acute care payment system of the future must be one that provides comparable incentives across delivery sites. While we will not stop our efforts to develop a prospective payment system for HHAs and another for SNFs, we should not be permanently wedded to separate payment systems for each of the self-contained post-acute care benefits. Rather, we should strive to better understand the value of each post-acute care provider type and how to better manage and coordinate care across the health care continuum.

Payment reform should ultimately support an infrastructure of post-acute and long-term care delivery systems that is better integrated and more flexible in meeting the needs of those with chronic conditions and disabilities. That is, a guiding principle in any lasting reform of the Medicare post-acute care benefits should be to make the system of services "beneficiary-centered." To be beneficiary-centered, an integrated delivery system needs a reliable and predictable stream of financing. It also requires a system of maintaining information on clients that is consistent and available to all service providers. This kind of information is essential as we work to target funds and determine how we go about fairly and accurately assessing what kind of care someone needs. Beneficiary-centered services also rely on inter-disciplinary case management that involves formal and informal caregivers and supports and encourages, where appropriate, beneficiaries to direct their own care. Finally, a beneficiary-centered system needs relatively standardized service packages typically provided by various health care professionals.

There is considerable overlap in the types of services provided and the types of beneficiaries that are treated in each of the post-acute settings. These distinctions are becoming increasingly blurred with advancing technology. For example, physical therapy and other rehabilitation services can be provided in each of the settings. A recent HCFA analysis shows that 53 percent of beneficiaries treated in the hospital for hip fracture use SNF services, 14 percent use home health services, and 14 percent use rehabilitation hospital services. Similarly, 25 percent of patients treated in the hospital for stroke use SNF services, 26 percent use home health services, and 16 percent use rehabilitation hospital services. While there may be some clinical differences in the patients who go to each of these settings and in the outcomes as a result of care provided in each of these settings, it is also likely that patient and physician preferences influence which type of post-acute service is used.

Despite the considerable overlap, Medicare's payment and coverage rules vary by setting. While I don't wish to discount the importance of beneficiary preference in making these decisions, I would like to ensure that Medicare payment is not the primary reason for care

setting decisions. Medicare payment methods and amounts for similar services provided in each of the post-acute settings differ. And more expensive stays do not always imply more services or better outcomes. For example, some provocative early research findings suggest that, for some conditions, outcomes may be no better for beneficiaries treated in one setting than another, even though Medicare payment may be substantially different. I am hopeful that further research into the characteristics of patients that use care in each of the post-acute settings, and an analysis of outcomes, can provide information about the most appropriate setting for different types of patients.

As I've suggested, any effort to control the utilization of post-acute care services and ensure equity and appropriateness of payment must involve a mechanism to track outcomes and services that address patient care needs. Such a mechanism ideally begins with a valid and reliable assessment screening instrument that would provide a preliminary assessment of the patient's needs and the types of services that would best meet desired health outcomes at the lowest possible cost. This type of instrument could also be used to assess the individual's values and preferences for continuing care, so that if two or more types of care would typically provide the desired outcomes at comparable costs, the individual could choose the type of care he or she would receive under Medicare. Such an assessment instrument should also be made up of core data elements (e.g., functional status, available care supports, etc.) that would be relevant across the care continuum and that would support case-mix payment systems.

As you may be aware, HCFA has been developing assessment instruments -- the Uniform Needs Assessment Instrument (UNAI), the long-term care facility minimum data set (MDS), and, of course, the OASIS for home care. The next challenge is to identify common elements among the instruments to support an integrated payment system.

Under a possible future payment scenario, we would want to provide payments sufficient to ensure that beneficiaries receive high quality care in the appropriate settings, and that any transfers among settings occur only when medically appropriate and not in an effort to generate additional revenues.

In an effort to make payment systems "site-neutral," we might also consider splitting apart payment of the "medical" services from the room and board services. That way, payment for the "medical" services can be the same for similar patients regardless of whether they are delivered in the home or in a nursing facility. This would help address problems related to the institutional bias as well as clarify the allocation of responsibilities between Medicare and Medicaid.

This discussion addressed our general direction regarding the future of post-acute care payments. My message is that we are thinking more broadly about an integrated reimbursement system for post-acute services even as we focus our attention on developing a prospective payment systems for HHAs.

Status of PPS Demonstration and Studies

We believe that it is critical to embark on a prospective payment system for home health care as soon as it is viable, and we are committed to working with Congress to design a prospective payment system that controls costs and also ensures quality and access. An empirically valid and reliable PPS will provide incentives to HHAs to make the most appropriate use of resources and, in the long term, will help control overall expenditures.

We have dedicated many resources toward developing a prospective payment system for HHAs. In fact, we are in the process of testing a prospective payment system through the National Home Health Agency Prospective Payment Demonstration. Demonstrations are very useful in testing the appropriateness of specific payment methodologies in advance of full implementation. They are also very useful in identifying methods that do not work well, and that we would not want to implement.

PPS Demonstration

The National Home Health Agency Prospective Payment Demonstration is testing two alternative methods of prospective payment. Phase I of the demonstration tested a per-visit prospective payment. Phase II of the demonstration, which began in June 1995, is testing a per-episode prospective payment, and will last for two more years.

In Phase I, we tested a per-visit payment method that established a separate payment rate for each of six types of home health visits (i.e., skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services), and found that this methodology is not effective in controlling home health expenditure growth.

In Phase II, we are examining the effect of an episode payment on spending, the number and types of visits provided, and quality of care. Participating HHAs are receiving an agency-specific episode payment based on 120 days of care and outlier payments for episodes that extend beyond 120 days. The prospective rates are based on an agency's costs in a base year, and are case-mix adjusted. Outlier visits are reimbursed at per-visit prospective rates. A new episode of care does not begin until there has been a gap in home health services for 45 or more days after the initial 120 days. Agencies receiving per-episode payments are subject to stop-loss and profit sharing provisions.

We do not yet have results from this phase of the demonstration. While we do not yet have an appropriate definition of an episode, we do know that we have concerns about a system based on a 120-day episode with all visits after 120 days paid as outliers. Outliers should represent unusual cases, not the norm. The integrity of a prospective payment system is violated if almost half of all visits are classified and paid as outliers. Consequently, we are continuing to explore through research the appropriate unit of payment and episode length.

Case-Mix Project

The case-mix adjuster used in the demonstration was developed to reflect case-mix changes within an agency from year to year, not across agencies. In any prospective payment system that we implement nationally, we would want a case-mix adjuster to differentiate case-mix across HHAs. We are currently funding a project that will lead to this type of a case-mix adjuster. This research will examine the relationship between patient characteristics and home health resource use and develop a case-mix adjustment system for our PPS system. This research will utilize the information on patient characteristics included in OASIS that all HHAs will be required to complete. Agency recruitment will begin shortly, and data collection will begin in the Fall of this year. Data collection will continue through October 1998 and analysis will take place through the end of 1998.

Volume-Outcome Study

Developing a prospective payment system is further complicated by the wide variation in the number of home health visits provided per home health user. In setting payment rate for a prospective payment system, it is important to know, within a range, what the appropriate amount of care is needed to produce the best possible patient outcomes. If HHAs are currently over or under providing home health care, we do not want to create incentives in a prospective payment system that continue the current utilization patterns. HCFA is sponsoring a study to examine the relationship between the volume of home health services received and patient outcomes. If this study is able to identify thresholds below and above which home health does not contribute to better outcomes, this might help us develop a prospective payment system that reflects the level of care that should be provided to produce the best possible patient outcomes.

The information we have gained from the demonstrations thus far laid the foundation for the payment proposals that are included in the President's FY 1998 budget submission.

FY 1998 Legislative Proposals

We proposed a number of home health payment reforms designed to achieve needed cost control, improve financial management, and control fraud and abuse. We have proposed interim payment controls until we can transition into a PPS in 1999.

National Prospective Payment System

There is broad agreement among industry representatives, and members of Congress, that a prospective payment system is the superior way to constrain costs without sacrificing access or quality. We have sketched out in our legislation some of the features that are desirable for such a system. The essence of any prospective payment system is the unit of payment and case-mix adjustments. The unit of payment for a home health prospective payment system

would need to be clearly defined. An appropriate case-mix adjuster that explains a significant amount of the variation in cost is also essential. In order to prevent un-bundling, we would anticipate that the prospective rate would cover all services currently covered and paid on a reasonable costs basis under the Medicare home health benefit, including medical supplies.

The prospective payment amount would be adjusted annually by the HHA market basket index. The labor portion of the prospective payment amount would be adjusted for geographic differences in labor-related costs based on the most current hospital wage index. The Secretary would have the authority to establish a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care. Finally, if a beneficiary elects to transfer to, or receive services from, another HHA, we would prorate the payment.

We are committed to implementing a prospective payment system for home health as soon as possible. There is, however, critical work remaining to be done before we can implement such a system -- namely, the development of a case-mix adjuster that can explain a significant amount of variation in costs per case, and the development of an appropriate unit of payment. Our legislative proposal seeks authority for the Secretary to implement a prospective system that meets these parameters. However, since many key elements are still in development, we do not believe that we can specify them in statute at this point. Our legislative proposal seeks authority to request data from HHAs to support our continued development of the prospective payment system.

Interim Payment System

While we continue to develop these essential features of a PPS system, we propose to implement some interim changes to our existing payment system that would allow us to achieve additional cost control. The Administration's proposal would rely on proven techniques of cost limit reductions to achieve guaranteed, up-front savings without disrupting the industry with a host of new payment methods.

In the interim, we would establish a new cost limit on top of the existing cost-based reimbursement. This new cost limit would build on agencies' actual experience in resource use per beneficiary in a base year. This cap on historical utilization or intensity per beneficiary will contribute to expenditure control during the time span of the interim system. The cap would give agencies the flexibility to provide the appropriate amount of care (duration of visits, number of visits, and skill level of caregiver) within this limit.

To be more specific, payment to an HHA would be the lesser of: (1) the agency's actual costs, or (2) a per visit cost limit set at 105 percent of the median national cost for free-standing HHAs, or (3) this new agency-specific per beneficiary annual limit. This proposal can be implemented immediately, with few administrative changes and little additional administrative burden on home health agencies, and allow for a sensible phase-in to

a prospective payment system.

You may ask why we would continue with a cost-based reimbursement system at all in the face of comments that a prospective payment system is preferable. First, as I've explained earlier, we simply will not have all of the necessary ingredients for a prospective payment system ready until October of 1999. Second, we can guarantee that the modification to the cost limit and the introduction of a per beneficiary cap will achieve scorable savings immediately upon implementation. We cannot make that assertion about any other system currently being discussed.

Finally, I ask you to consider this: at a rhetorical level, it is easy for some to state that cost-based reimbursement is inherently bad (because it provides incentives to increase costs up to the statutory limit) and that a prospective payment system in inherently good. We need more time to develop a prospective payment system that contains a reliable case-mix adjuster to protect beneficiaries against cream-skimming and under-service. A good prospective payment system is better that a cost-based system, but a cost-based system is certainly better than a poorly designed prospective payment system without an appropriate case-mix adjuster.

In addition to our payment proposals, we have a number of proposals designed to close existing loopholes for inappropriate billing and payments.

Eliminate PIP Payments

We propose to eliminate periodic interim payments (PIP) for HHAs simultaneous with PPS implementation in 1999. PIP was established to encourage new providers to participate in Medicare by improving cash flow by paying a set amount on a bi-weekly basis. However, with about 100 new HHAs joining Medicare each month, access to home health is no longer a problem. Further, the Office of the Inspector General has found that Medicare tends to overpay providers who receive PIP, and has validated our contention that it is sometimes difficult to recover these overpayments.

Payment at Location of Service

We propose to base payments on the location where services are rendered, not where services are billed. Many HHAs are established with a parent office in an urban area and branches in rural areas. When these HHAs bill Medicare, the payment is based on the higher wage rate for the urban area even though the service delivery occurred in a lower-cost rural area.

Clarify the Definition of "Homebound"

We also propose to clarify the "homebound" definition by adding several calendar month benchmarks to emphasize that home health coverage is only available to those who are truly

unable to leave the home. The current statutory definition is vague and overly broad. It allows for considerable discretion in interpretation, and for waste, fraud, and abuse. Financial reviews show that Medicare routinely reimburses care to beneficiaries who are not truly homebound. Without a more concrete definition, this eligibility requirement is very difficult to enforce. The March 1996 GAO report cites the problematic homebound definition as contributing to excessive spending and fraud and abuse.

Provide Secretarial Authority to Make Payment Denials Based on Normative Service Standards

We also seek the authority to work with the health care community to establish normative numbers of visits for specific conditions or situations. For example, HCFA could establish a normative number of aide visits for a particular condition, and deny payment for those visits that exceed this standard. Allowing the Secretary to establish more objective criteria will help HCFA gain more control over excessive utilization. The March 1996 GAO report criticizes current statutory coverage criteria as leaving too much room for interpretation and inviting fraud and abuse.

Restore Post-Hospital Home Health Benefit Under Part A and Reallocate Other Home Health Services to Part B

I know you are aware of our proposal to reallocate financing of a portion of the home health benefit from Part A to Part B. Under our proposal, the first 100 home health visits following a three-day hospital stay would be reimbursed under Medicare Part A. All other visits, including those not following a hospitalization, would be reimbursed under Part B. Part B visits would not be subject to the Part B coinsurance or deductible. The transfer would not affect the Part B premium.

Clearly, by limiting Part A financing of the home health benefit, we would be saving the financially vulnerable HI Trust Fund about $80 billion over 5 years. This is an important motive, and I note that Republican members voted to achieve the same goal with a similar technique. An unintended consequence of the OBRA 1980 change was to burden the Part A Trust Fund with approximately 99 percent of the financing for the home health benefit, regardless of whether or not visits are related to a hospital stay. The huge shift in financing to Part A clearly was not consistent with the original intent of Part A, the Hospital Insurance Trust Fund, which was designed to only finance services that centered around a hospitalization.

We deliberately excluded the impact of this Part B financing from the calculation of the Part B premium. We are concerned about the impact that higher beneficiary out-of-pocket expenses would have on poorer Medicare beneficiaries. Currently, Medicare beneficiaries spend an average of $2,605 on out-of-pocket health expenditures; this accounts for 21 percent of family income of Medicare beneficiaries. Poorer beneficiaries spend a greater proportion of

their income on out-of-pocket costs.

Comparison with Industry Proposal

We have heard some criticism about our approach of continuing cost-based payment until we have an adequate case-mix adjuster to use in a prospective payment system. The industry has offered an alternative proposal that moves to prospective rates sooner. Let me take this opportunity to highlight some of our concerns about moving too quickly to a prospective payment system which we think contains a number of flaws that could damage beneficiary access to service and result in increased expenditures (rather than expenditure control).

One concern is that the proposal would force us to use the 18-category patient classification system from our Phase II demonstration as a means to case-mix adjust a 120-day episodic expenditure cap. As I described before, the demonstration's classification scheme was designed merely to measure resource intensity changes from one year to another within an individual agency. It was not designed nor intended to measure resource-use differences among all home health patients and across all agencies in the country, and it would perform poorly in this manner. Moreover, the classification scheme explains less than 10 percent of the variation in costs -- far less than the initial DRG system for hospitals. We have research underway to develop a case-mix measure to adjust payment rates for our PPS. The development of a case-mix adjuster to adjust an expenditure cap would require additional research.

Some would want you to believe that it is better to implement a bad PPS system now rather than wait for a valid and reliable system in two years from now. We are convinced that savings cannot be guaranteed under an untested, unreliable new payment methodology that uses an inappropriate case-mix adjuster.

Another concern about the industry proposal is that it would pay per-visit rates subject to a 120-day expenditure cap. As I already mentioned, results from our demonstration show that per-visit rates do not hold down Medicare costs. As to the 120-day episodic cap, I have already mentioned our concerns about using a 120-day unit of payment since about 40 percent of all home health visits would fall outside of this cap.

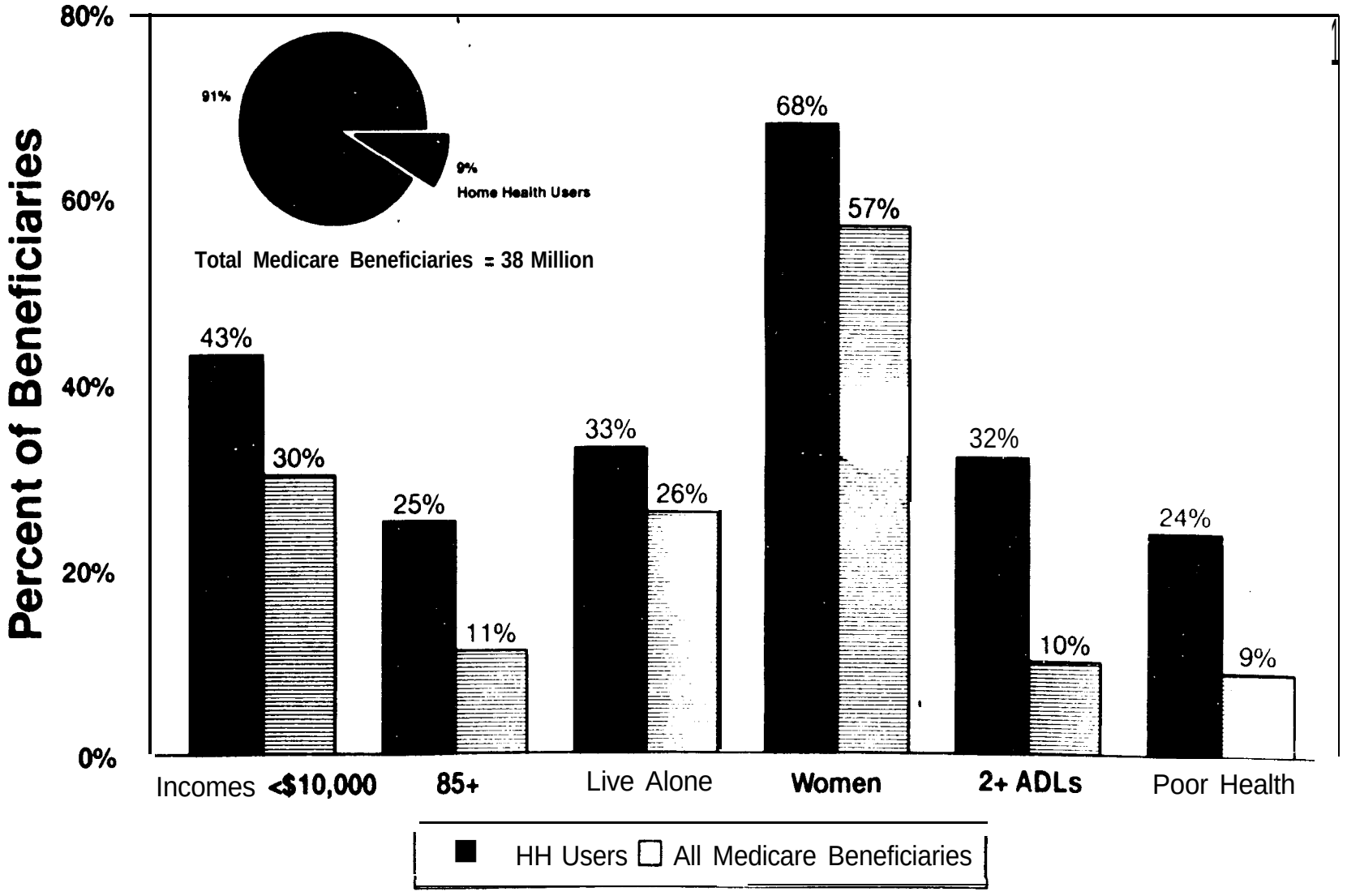
As a concluding note, I should add that making huge changes to our current payment system in the interim could divert resources away from the development of a reliable PPS, and toward the implementation and maintenance of an unwieldy and unreliable interim system.

Conclusion

There is widespread agreement that HHA expenditures are growing rapidly, that continued growth of this magnitude is unsustainable, and that legislative efforts are needed to slow down

this growth. I have laid out for you today our vision for the future of the home health benefit and its payment system. It is my hope that we can work together to develop payment policies that provide the right incentives -- incentives to provide quality care, promote access to care, and inhibit fraud and abuse. Thank you for the opportunity to testify today.

Characteristics of Medicare Home Health Users



Source: HCFA 1994 Medicare Current Beneficiary Survey

REFORMING MEDICARE'S HOME HEALTH BENEFIT
Legislative Proposals from the President's FY 1998 Budget

- **Prospective Payment System** -- implement a PPS for HHAs in October 1999, with valid and reliable case mix adjustment system
- **Interim Payment System** -- effective until October 1999, achieve necessary expenditure control by reducing the HHA cost limit and introducing an annual "per beneficiary" cap
- **Payment at Location of Service** -- base payments on the location where the home care is furnished, not where the HHA office is located
- **Eliminate Periodic Interim Payments** -- effective at the introduction of PPS, eliminate unnecessary bi-weekly estimated payments
- **Clarify the "Homebound" Definition** -- bring clarity to the Currently vague definition (by adding several calendar benchmarks) to emphasize that the benefit is available only to those who are truly unable to leave the home
- **Give the HHS Secretary Authority to Deny Payments Based On Normative Service Standards** -- allows us to work with the industry to establish normative visit standards for specific clinical conditions or situations
- **Restore Post-Hospital Home Health Benefit Under Part A and Transfer Other Home Health Service to Part B** -- restores the HI Trust Fund to its intended purpose and extends its solvency into 2007